FORM TO BE USED BY A PRISONER IN FILING A COMPLAINT UNDER THE CIVIL RIGHTS ACT, 42 U.S.C. SECTION 1983

In the United States District Court for the [redacted] District of New York NORTHERN

3-10-CV-201

MR. [redacted] BRADY BICKEL

Enter above the full name of the plaintiff in this action.

VS.

SUNY UPSTATE MEDICAL UNIVERSITY SYRACUSE, NEW YORK

Enter above the full name of the defendant or defendants in this action.

I. Parties

(In item A below, place your full name in the first blank and place your present address in the second blank. Do the same for any additional plaintiffs.)

A. Name of Plaintiff BRADY BICKEL

Current Address BROOME COUNTY CORRECTIONAL FACILITY P. O. Box 2047, Binghamton NY. 13902-2047

(In item B below, place the full name of the defendant in the first blank, his official position in the second blank, and his place of employment in the third blank. Use item C for the same information regarding any additional defendants.)

B. Defendant SUNY UPSTATE MEDICAL UNIVERSITY is employed as SCHOOL OF MEDICINE at STATE UNIVERSITY OF NEW YORK, SYRACUSE

C. Additional Defendants _____

II. Statement of Claim

State here as briefly as possible the *facts* of your case. Describe how each defendant is involved. Also include the names of any other persons involved, dates and places of events. You may cite Constitutional Amendments you alleged were violated, but do not give any legal arguments or cite any cases or statutes. If you intend to allege a number of related claims, number and set forth each claim in a separate paragraph. Use as much space as you need. (Attach additional sheet if necessary).

ON DEC. 3rd. 2009, I WAS CHARGED WITH THE DEATH OF MY GIRLFRIENDS (SARAH DIBBLE) INFANT (JULIANNE DIBBLE) WHO DIED Sept. 30th. 2009. IT WAS PERTINENT TO HAVE THE POST-MORTEM EXAMINATION, FOR THERE WERE QUESTIONS OF TRAUMA TO JULIANNE (ONLY TWO MONTHS OLD) THAT ALL THE PHYSICIANS CONCURRED TO CONSULT SHOULD BE DONE. YET, STAFF WAS MORE CONCERN IN GETTING A POWER OF-ATTORNEY FOR INSURANCE, THEN SIGNING OFF THE "DONOR REFERRAL" INSTEAD OF KEEPING BRADY BICKEL.

III. Relief

Briefly state exactly what you want the court to do for you. (Make no legal arguments. Do not cite cases or statutes.)

THE EXHUMATION OF JULIANNE DIBBLE, AFFIDAVIT FROM LEAD PHYSICIAN DR. HANNAN AND ALL OTHER CONSULTS. DEPOSITIONS FROM HASH VALENTINE & SCANLON AS TO HOW THERE NOTES LED TO THE INCARCERATION OF BRADY BICKEL, UNAUTHORIZED BY ANY COURT AND THE SUM OF 50 MILLION DOLLARS AND SUCH FURTHER AND OTHER RELIEF DEEM JUST BY THE COURT.

( ) Jury Trial (X) Non-Jury Trial

IV. Place of Present Confinement _____

A. Is there a prisoner grievance procedure in this Institution? (X) Yes No ( )

B. Did you present the facts relating to your complaint in the state prisoner grievance procedure?
Yes ( ) No (X)

C. If your answer is YES:

1. What steps did you take? _____

2. What was the result? _____

_____

D. If your answer is NO, explain why not I AM DEFENDANT IN THIS LEGAL MATTER AND EVIDENCE JUST CAME TO ME.

E. If there is no prison grievance procedure in the institution, did you complain to the prison authorities?
YES ( ) NO (X)

F. If your answer is YES:

1. What steps did you take? _____

_____

2. What was the result? _____

_____

V. Previous Lawsuits

A. Have you ever begun other lawsuits in any state or federal court relating to your imprisonment?
YES ( ) NO (X)

B. If your answer to A is YES: You must describe any lawsuits, currently pending or closed, in the space below. (If there is more than one lawsuit, you must describe the additional lawsuits on another piece of paper, using the same outline.)

1. Parties to previous lawsuit:

Plaintiff(s) _____

_____

Defendants _____

_____

2. Court (if federal court, name the District; if state court, name the county):

_____

3. Docket number:

4. Name of Judge to whom case was assigned _____

5. Disposition (was the case dismissed? appealed? still pending?)

_____

6. Approximate date of filing lawsuit _____

7. Approximate date of disposition _____

I declare under penalty of perjury that the foregoing is true and correct.

2/18/2010 Brady Bickel
(Date) (Signature of Plaintiff)

SUNY Upstate Medical University
University Hospital

Patient Name: DIBBLE, JULIANNE
Last First
MR#: 1274910 Account #: 53383385
DOB: 07/22/2009 Age: 2MOS Gender: F
Admit Date: 09/28/09

LIMITED POWER OF ATTORNEY TO PURSUE PAYMENT AND APPEALS FOLLOWING DENIAL BASED ON MEDICAL NECESSITY AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION ("LIMITED POWER OF ATTORNEY")

I, the patient or someone authorized to act on the patient Julianne Dibble 's behalf, appoint **University Hospitals** my Health care Provider, located at 750 East Adams St., Syracuse, NY 13210, to have **Limited Power of Attorney** to pursue payment from my insurance company or governmental plan for services provided by University Hospital and to pursue any appeals, etc.. I also authorize University Hospital to pursue any appeals available to me under my Health Plan's policies or procedures and applicable law, including but not limited to external appeals under State or Federal laws relating to health care services provided by the Health Care Provider. I give permission for University Hospital to act in any way I could act personally. University Hospital will take all reasonable actions, as my agent, to pursue payment and if necessary an appeal. University Hospital will only use this Limited Power of Attorney when my insurance company or government plan has denied payment based on medical necessity. University Hospital will not charge me for services used in pursuing payment or an appeal on my behalf. I agree that my insurance company or government plan will pay any amount owed directly to University hospital for these services.

In pursuing such payment and/or an appeal:

I authorize University Hospital and my insurance company to release all relevant medical information, including (if applicable) any HIV-related, mental health treatment or alcohol/substance abuse treatment information, relating to my Health Plan's denial of payment. I understand that this information will only be released as necessary, to the following: my Health Plan, an external appeal agent, arbitrator, court of law and/or other third party reviewer ("Independent Reviewer"). I understand that my Health Plan and/or the Independent Reviewer will use this information to make a decision about payment to University Hospital. I also understand that the decision by the Independent Reviewer will be the final legal decision for me, University Hospital and the Health Plan.

I authorize University Hospital to complete, execute, acknowledge, seal and to deliver any consent, demand, request, application, agreement, authorization or other documents necessary, to request,

Patient Name: DIBBLE ,JULIANNE
Last First

MR#: 1274810 Account #: 53388585

DOB: 07/22/2009 Age: 2MOS Gender: F

Admit Date: 09/28/09

SUNY Upstate Medical University
University Hospital

on my behalf, payment and/or appeal to my Health Plan and, if applicable, to the independent reviewer, the New York State Department of Health, the State Insurance Department, the US Department of Health and Human Services, the US Department of Labor and/or any other other applicable agency.

This Limited Power of Attorney shall not be affected by my subsequent disability or incompetence and may be revoked by me at any time upon prior notice to the Health Care Provider. This Limited Power of Attorney, including authorization for release of medical information, will end one (1) year from today's date unless I agree to extend it beyond that date.

Any person or entity receiving this document may rely on a copy as if it were an executed original.

IN WITNESS WHEREOF, I have signed my name this 28th day of September, 20 09

YOU SIGN HERE: Sarah Dibble

PRINT NAME: Sarah Dibble

ADDRESS: 413 PERRY ROAD

BINGHAMTON NY 13905

WITNESS:

PRINT NAME/TITLE: T. Eldred PAS Clerk

ADDRESS: 750 E. ADAMS STREET

SYRCUSE, NY 13210

SUNY Upstate Medical University
University Hospital

Patient Name
DIBBLE ,JULIANNE
Admit Date
09/28/09
Med Rec #
1274810
Date of Birth
07/22/2009
Account #
53388385

CONSENT FOR POST-MORTEM EXAMINATION

As legal next-of-kin _____
I, (we) authorize University Hospital, and any physician selected by it, to perform a post-mortem examination to determine the cause of death or to verify the cause of death, or for the following specific purposes: _____

_____

Authorization is granted for the removal of tissues as such physician(s) may deem appropriate and desirable for microscopic examination and for the preservation and study of any and all tissues or parts that may be removed, and for their disposal following study.

Limitation on extent of post-mortem examination-specific instructions: (If none, write "None")

_____

_____

I do not know of lawful objections to performance of this post-mortem examination held by the deceased patient or by others equally entitled to grant or withhold their authorization.

Signature (next-of-kin): _____ Relationship: _____

Signature (next-of-kin): _____ Relationship: _____

Signature (next-of-kin): _____ Relationship: _____

Signatures must be witnessed

WITNESS:

Signature: _____ Print/Stamp: _____ Date/Time: _____

PHYSICIAN:
I have discussed the information described above with the relative(s) or guardian(s) whose signature(s) appear on this document.

Signature: _____ Print/Stamp/Title: _____ Date/Time: _____

Please indicate physicians to whom additional copies of report should be sent:

_____

_____

_____

Pathologist May Not Proceed With Examination Unless Proper Signature(s) Have Been Obtained and the Permit Has Been Checked To be Sure It Is Completed and Satisfactory.

SUNY Upstate Medical University
University Hospital

Patient Name
DIBBLE ,JULIANNE
Admit Date
09/28/09
Med Rec #
1274810
Date of Birth
07/22/2009
Account #
53388385

Patient Name: _____

DONOR REFERRAL

MR#: _____ DOB: _____

Notify Statline with all impending and actual deaths.
1-800-894-9914

Date of call: 9.29

Time of call: 2358

Reference Number: 72838l4

Does the patient meet the criteria for screening potential as an organ/tissue donor?:

☒ **Yes**

☐ **No**

If, NO please explain _____

Signature: Anna Perrya Title: RN Date: 9.29

F83023–Donor Referral Rev. 6/2004

MR N